CHARLTON MANOR REST HOME

Confidential Application for Residency

I. General Information

Applicant Name: (Last)________________ (MI)______ (First)________________

Address:________________________________ How long at this Address?______ yrs.

City: ________________________ State:__________ Zip Code: __________

Telephone where applicant can be reached? ________________________________

Gender: ________ Date of Birth:_____/___/_____ Birth place: ________________

Phone #: ________________ Social Security #: ________________________

II. Resident Profile

Marital Status (circle one): Married Single Widow/er Divorced Separated

Spouse's Name:____________________________ Date of Birth:_____/___/_____

If Spouse is deceased, date and cause of death:________________________________

Former Occupation:____

Length of employment__________________ Date of retirement ________________

Religion __________________________ Church ________________________

In case of an emergency or necessity, whom should we call?

Name: ____ Relationship __________

Address:____________ State ____________ Zip code ________ Phone:__________

Name: ____ Relationship __________

Address:____________ State ____________ Zip code ________ Phone:__________

Next of Kin (if different than above)

Name: ____ Relationship __________

Address:____________ State ____________ Zip code ________ Phone:__________

Name: ____ Relationship __________

Address:____________ State ____________ Zip code ________ Phone:__________

III. Current Living Situation

Do you currently own your own home or rent?________________________________

What type of housing do you live in? ____

Do you own an automobile?_____ Make and Year:________________

Do you drive yourself regularly?____ Do you intend to maintain a car? ______

Are there any problems or concerns that our staff should be aware of, or any special support you might need to live in our community? ________________________________

____

IV. Medical and Insurance Information

Physician's name: ____________________

Address: ____________ State ____ Zip code ______ Phone#: ____________

Hospital Affiliation: ____________________

How would you describe your present state of health? ____________________

Do you have any allergies to food or medicine? ____________________

How often do you see your doctor? ____________________

Are you on any medications at the present time? _____ *If yes, please describe (Continue on back if necessary):*

____

Are you planning on keeping your own doctor or will you be switching to the visiting primary care physician at **Charlton Manor** ____________________

How much walking do you do?__________ Do you have any difficulty with stairs?_______

Do you use any assistance such as a cane, walker, or wheelchair? ______ Type:__________

Please list all of your medical insurance coverages, including supplemental and long-term care:

____________________ **Policy No.:** ____________________

____________________ **Policy No.:** ____________________

V. Daily Living

Please use an "X" to indicate your level of ability in the following areas:

Task	**"I can handle this myself"**	**"I need some assistance"**	**Comments:**
Bathing			
Dressing			
Mouth or Skin Care			
Shaving or Grooming			
Toileting			
Walking/mobility			
Med Reminder			
Night Care			

Do you fill your own prescriptions? ____________________

If you need a medicine reminder, will you be using the pharmacy Charlton Manoruses to deliver prescriptions? ____________________

Is there any other information we should be aware of when reviewing your health and medical concerns?

Mental Status:__________ Alert __________ Forgetful __________

Anxious __________ Aware of time/place __________

Has applicant been diagnosed with Alzheimer's Disease? ________ Dementia? ________

Has applicant been diagnosed as mentally ill or mentally retarded? ____________________

Please describe temperament of applicant: ____________________

What are your personal strengths and interests? ____________________

How do you like to spend your time?____________________

Income Sources

The following worksheet is necessary to determine if your financial resources are adequate to cover the monthly living costs at Charlton Manor Rest Home. This information is kept confidential and can be used to determine if you may be eligible for our Medicaid program.

Employment Income: $____________ per month; Social Security: $____________ per month

Employer Pension: $____________ per month; Life Insurance Benefits: $________ per month

Annuity Income: $____________ per month; Support from Family: $________ per month

Interest & Dividend Income: $____________ per month; Other: $____________ per month

Total Monthly Income: $________________ per month

Please List Any Bank Accounts

Checking Account:

Financial Institution: ____

Address: ______________________________ State: ______ Zip Code: __________

Phone #: ____________________ Account #: ____________________________

Who will be responsible for the payment of your bills? Self ____ Other Person ____

Name and address of "Other Person":

Name: ____ Phone: ____________

Address: ____

City: ______________________ State: ______________ Zip Code: __________

Relationship (e.g. Power of Attorney, Conservatorship): ______________________

Have you designated someone with Financial Power of Attorney to manage your affairs? Yes No

Please describe any Advance Directives you may have in place (i.e. power of attorney, health care proxy, DNR, living will, conservator, guardian) and list name, address, and phone number of person who holds such power. Please furnish a complete copy of the authorizing document, as well as any trust documents, wills and codicils which may pertain to these powers.

Type of Advance Directive: ____

Held by/Name: ____________________________ Relationship: ____________________

Address: ____ Phone: ____________

City: ______________________ State: ______________ Zip Code: ____________

Other Directives: ____

Held by/Name: ____________________________ Relationship: ____________________

Address: ____ Phone: ____________

City: ______________________ State: ______________ Zip Code: ____________

I certify that the information I have given in this true and correct. I understand that any false statements, misrepresentations or omissions may result in the cancellation of my application. All information submitted by the applicant will be held in strict confidence.

Applicant Signature: ____ Date: ___/___/___